

AT-RISK ERGONOMIC ASSESSMENT REQUEST

EMPLOYEE COMPLETES THIS SECTION				
EMPLOYEE FIRST NAME	EMPLOYEE LAST NAM	ЛЕ	EMPLOYEE ID#	
DEPARTMENT/AGENCY	JOB TITLE/CLASSIFICATION		EMPLOYEE GROUP or UNION	
WORK TELEPHONE	WORK EMAIL ADDRESS		FLOOR & PILLAR NUMBER	
BUILDING NAME	BUILDING ADDRESS + SUITE # (if applicable)		CITY	
COUNTY	SUPERVISOR NAME		SUPERVISOR TELEPHONE	
AVAILABLE PARKING OPTIONS FOR THE SAFETY PROFESSIONAL/ERGONOMIC SPECIALIST Free parking Metered Street Parking Hourly Ramp Parking Location of Parking:				
ACKNOWLEDGMENT				
❖ I understand an At-Risk Ergonomic Assess				h - 4 D :11
❖ I understand an At-Risk Ergonomic Assessment may not result in new equipment or work surface adjustments, and that my Department will determine the appropriate implementation of any suggestions for equipment or workstation adjustments.				
Employee Signature			Date	
	STING PHYSICIAN (COMPLETES THIS S	SECTION	
REQUESTING PHYSICIAN COMPLETES THIS SECTION An At-Risk Ergonomic Assessment requires the support and signature from a licensed physician (M.D. or D.O.) or doctor of chiropractic (D.C.); this program is not intended to address return-to-work situations, work-related injuries, or Disability Accommodation Requests based on a medical need.				
Please print clearly and do not include a medi- PHYSICIAN'S REQUEST	cai diagnosis.			
	1/C4-4 C N/L-	1		
The above-named patient/State of Michigan employee is under my care and based on their medical condition, an ergonomic assessment is appropriate.				
bused on their intedical cor			sment is appr	opriate.
PHYSICIAN NAME	LICENSE TYPE (M.D., 1		clinic/office tele	
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PHYSICIAN NAME CLINIC/OFFICE ADDRESS	LICENSE TYPE (M.D., 1	D.O., D.C.) PHYSICIAN SIGNATU	CLINIC/OFFICE TELE RE	PHONE DATE
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